1976-12-10

P/S/R/O update: December 10, 1976 no. 27

P/S/R/O Update

Boston University Medical Center

December 10/76
Number 27

The Medical Cost/Quality Newsletter

DHEW releases interim regs for PSRO disclosure of certain types of information

Interim confidentiality regulations, published Dec. 3 in the Federal Register, will allow "public disclosure of certain data and information acquired by PSROs," according to a DHEW announcement. The release of PSRO information potentially beneficial to many users of health data, including Health Systems Agencies (HSAs), has been prohibited by statute until regulations are published.

TWO TYPES OF DATA

The proposed regulations will allow PSROs to share data and information that do not violate the privacy of individual patients, according to the DHEW. The disclosure of two types of PSRO data and information is permitted in the proposed regulations:

--data that have been published, which have not been termed confidential by the source of the data or information, and the disclosure of which is not otherwise forbidden by law; and

--those summary statistics gathered from the Uniform Hospital Discharge Data Set that cannot be traced to an individual patient or health practitioner. (The UHDDS is a "minimum basic data set developed under the auspices of DHEW to serve as core data

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N.Y. State health teams cite abuse in Medicaid, but PSROs take issue with some findings

NEW YORK, N.Y.--State health department on-site teams have been issuing headline-grabbing reports of abuses of Medicaid by hospitals, but PSRO officials suggested, when queried by PSRO Update, that abuses do not appear as widespread as reported.

10,868 PATIENT RECORDS CHECKED

The teams, checking records thus far of 10,868 patients at 65 hospitals, 31 of which are in New York City, denied Medicaid reimbursement in 401 cases. They listed such abuses as admissions of patients who did not require hospitalization, prolonged stays, weekend leaves with hospitals still charging for bed occupancy, and questionable admissions for surgery.

In an important analysis, health attorney John Blum discusses the role of PSRO in investigation of fraud and abuse. Page 8.

The New York Times ran headlines such as these: "Millions in Medicaid Overbillings Laid to New York City Hospitals," "Hospitals Found Taking Patients Just to Get Most Out of Medicaid," and "New York Health Officials Say System Encourages Unnecessary Hospital Admissions."

State and city health officials said the abuses included admission of patients for treatment of a minor rash or removal of a wart; admissions for laboratory tests that could have been performed in a physician's office or in an outpatient clinic; and patients demanding hospitalization because Blue Cross doesn't pay for visits to a physician's office.

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PSRO Update, which covers the federally mandated Professional Standards Review Organization program and the broader field of medical cost and quality, is published monthly by Boston University Medical Center Address editorial inquiries to **PSRO Update,** 720 Harrison Avenue, Suite 300, Boston, MA 02118. Telephone (617) 247-5606. Address subscription inquiries to **PSRO Update,** 306 Dartmouth Street, Boston, MA 02116, Telephone (617) 267-7100. Executive Editor/Donald R. Giller. Managing Editor/Owen J. McNamara. News Editor/Barbara Mackey. Contributing Editors/Nancy Haslam, Lorraine Loviglio, John Blum. Correspondents throughout the nation. Staff assistants/Carol Bernbaum, Rose Razzino.

N.Y. State health teams cite abuse in Medicaid, but PSROs take issue with some findings

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From the PSRO perspective, executive director Harry Feder of the Bronx PSRO, for one, questioned the validity of certain rulings in which state on-site teams, under the debated Chapter 76 of the Medicaid law, are determining what is deferrable surgery. He pointed out that, for example, a deferred hernia operation may not save the state money, since the later operation may be more difficult, and thus possibly more expensive.

WITHDRAWAL A THREAT

As for abuses, Feder said the PSRO is prepared to withdraw delegation if hospitals fail to follow the prescribed procedures. The hospitals realize the consequences of such withdrawal, and "ultimately PSRO has the authority to cut off Medicare and Medicaid funding," Feder pointed out. He added that the PSRO is the first organization to have "some teeth." They may be "baby teeth," at present, but they will grow, he added.

Eugene O'Reilly, executive director of the Nassau Physicians Review Organization in Nassau County, felt confident that the PSRO, given time, can "correct most of the abuses."

"There have been abuses," he said. "Nobody questions that some physicians will abuse hospital privileges and utilization. However, the reasons for such abuses are not always as clear as the state would like to say they are. There are often mitigating circumstances, so, for this reason, all alleged abuse is not just a black-and-white situation."

O'Reilly said the PSRO had begun the task of identifying the utilization patterns, but added that it would take time. He cited the lack of computerized data and the need to study such accumulated data when available.

THEY WANT IT 'YESTERDAY'

O'Reilly complained that the state officials are not satisfied by steps some hospitals have already taken to control some physicians on admissions. "They want everything to happen yesterday," he said.

O'Reilly also criticized the making of decisions about hospital patients by a state nurse coordinator in one Nassau hospital, who telephones a physician in the state regional office in White Plains, discusses a case and gets a decision from him. A few hospital stays have been terminated in this way, he said. "This physician doesn't see the patient or even the patient's chart," O'Reilly said.

John Podesta, executive director of the Kings County Health Care Review Organization, said he had not seen any evidence in four delegated Brooklyn hospitals of the abuses cited by the state teams.

There may be abuses, but "they just haven't surfaced in these four hospitals," Podesta remarked.

"We're monitored by a fiscal intermediary that has questioned only one case after a year," he said, "so the track record of these hospitals is pretty good."

BILLING PRACTICE CITED

Roger Herdman, M.D., deputy state health commissioner, told PSRO Update that the teams found abuses throughout the state, and that some of the "most prestigious hospitals" in New York City, as well as in other parts of the state, had engaged in so-called "therapeutic leaves" for psychiatric patients for which Medicaid was billed. "Such billing has now stopped," he said.

Herdman said that the PSROs can eliminate the abuses "by doing the same things we are doing, by familiarizing themselves with what's proper under federal and state laws, and taking a tough approach on these violations." He added, however, "We are still in a cordial but adversary position with the PSROs."

Herdman said that reports from on-site teams indicate that the average length of stay of Medicaid patients is about three days less than when the state on-site teams began their visits Sept. 1. He declared that the state would be "delighted if the PSROs would have the same impact on hospital patterns as we have had, and take this off our shoulders." However, he declared, the PSROs at this time are mostly conditional, "do not have a track record" and are "asking us to cede control" over hospitals whose Medicaid billings amount to $1 billion per year. ■

PSRO directors cite reduction in LOS in answer to criticism of hospital utilization patterns

NEW YORK, N.Y.--In partial response to state health officials' criticism of hospitals for encouraging overutilization by Medicaid patients (see preceding story), two PSRO directors cited some reductions in lengths of stay under PSRO review.

Reduction of length of stay appears to have occurred in all four delegated hospitals in Area 9 PSRO (Westchester and Putnam counties), according to Michael Maffucci, executive director. He said that 14 days had appeared to be an average length of

stay, and "we've reduced it to 13 1/2 days in some hospitals for Medicare patients."

NO CLEAR PICTURE YET

Maffucci pointed out that complete records are not yet available, because of the short period PSRO has been operating. Only one hospital has had delegation for three quarters of the year, and thus, "it is difficult to get a clear picture," he said.

Harry Feder, executive director of the Bronx PSRO, said that Blue Cross had reported a half-day reduction in length of stay of Medicare patients in Bronx hospitals. Nine hospitals have been delegated.

The Bronx hospitals have had a 10.8 days average length of stay, which is one of the lowest in urban areas in the country, Feder said.

The New York Times, in its coverage of Medicaid abuses, had reported that 11.2 days was the average length of stay for New York City hospitals, compared to a national average of 7.8 days. The room rate for New York City hospitals averages $200 a day. ■

DHEW releases interim regs for PSRO disclosure of certain types of information

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for multiple users of hospital discharge data.")

AWAIT FINAL REGS

The proposed regulations will be effective until final regulations are written.

Public suggestions may be incorporated in a possible revision of the interim regulations or in the final regulations, the announcement said. Comments should be mailed within 45 days to the Director, Bureau of Quality Assurance, Health Services Administration, Room 16A-55, 5600 Fishers Lane, Rockville, MD. 20857. ■

Bay State becomes first to have state PSR Council; 4 states to follow in Dec.

Massachusetts last month became the first state to acquire a state PSR Council when 13 persons accepted invitations to serve. Council members in Pennsylvania, New York, Maryland and California are expected to be named this month.

FIRST MEETING SET

The Massachusetts council will hold its organizational meeting Dec. 22. Among the 13 members are nine physicians, all of whom were designated by either the PSROs, the state medical society or the state hospital association. The four public members, all active in health groups, were nominated by the governor and by the DHEW Region I health administrator, and appointed by the DHEW Secretary.

The members and their affiliations are: Robert J. Brennan, M.D., Bay State PSRO; Richard C. Kerr, M.D., Charles River PSRO; Robert N. LaMarche, M.D., Western Massachusetts PSRO; Edward Mason, M.D., Central Massachusetts PSRO; and Samuel K. Stewart, M.D., Southeastern Massachusetts PRO (SEMPRO);

also, H. Thomas Ballantine, Jr., M.D., and James F. McDonough, M.D., Mass. Medical Society; Chilton Crane, M.D., and Walter Mozden, M.D., Mass. Hospital Association;

also, Peter Morgan Bloomsburg, Thomas F. Connolly, D.P.M., John W. Lund and Betty L. Wornum, all public members.

Bloomsburg is employed in the state Medicaid program; Connolly is a podiatrist who is active in mental health programs; Lund is a businessman who has served on the governor's advisory committee for comprehensive health planning; and Wornum has been involved in neighborhood health activities.

ROLE OF STATE COUNCILS

States having three or more conditional PSROs are required by the PSRO law (P.L. 92-603) to have a state PSR council. The major responsibilities are: to hear appeals from practitioners of decisions made by PSROs; to review sanctions reports as they are routed to the Secretary; to assist the Secretary in evaluating PSROs; and to help coordinate PSRO activities in the state and disseminate information among them. ■

The ayes of Texas favor single statewide PSRO; next move up to Mathews

In an unofficial vote tallied last month, physicians in Texas have told the Secretary of DHEW in unequivocal terms that they oppose having more than one PSRO area for the state. Eighty-six percent of the 11,058 valid ballots affirmed the single statewide-PSRO concept; 16,101 physicians were deemed eligible to vote.

The vote, called advisory and nonbinding by Secretary David Mathews, was taken after a federal district court last January erased the PSRO boundaries that DHEW had originally drawn; these boundaries had divided Texas into nine PSRO areas. (See PSRO Update, Jan., Feb., Aug., 1976.)

Mathews now must take the next step. He has several choices, but the outcome of

all courses seems to be the creation of a single PSRO area for Texas. The immediate questions are how long it will take to arrive at that designation and how strictly he should follow the legal guidelines along the way.

LEGAL SNARES SEEN

Assistant Secretary for Health Theodore Cooper, M.D., has reportedly recommended that Mathews designate the single-PSRO area straight away. However, legal opinions within DHEW are said to caution that such action would violate the guidelines that have been used to set up PSRO areas. However, if the Secretary violates the guidelines by designating a single-PSRO area, as long as the decision is not challenged, it would stand. This action appears to be the speediest course for getting PSRO started.

The other major choice calls for proceeding through the steps, in all their technicalities, to designate new areas; this includes taking an official poll of physicians by area. ■

Draft transmittal puts forth guidelines for developing PSRO-HSA agreements

A guide to developing written agreements between PSROs and Health Systems Agencies has been issued jointly by the Bureau of Quality Assurance and the Bureau of Health Planning and Resources Development. (See PSRO Update, Nov., 1976)

COVERS FOUR AREAS

The guidelines, issued by BQA as a draft transmittal, describe four areas that each agreement must cover: sharing data and information; review of the HSA's health system plan (HSP) and annual implementation plan (AIP) by the PSRO; exchange of technical assistance; and assurance that actions taken by the PSRO will be consistent with the HSP and AIP for the area.

Sections recommended to be included in any written agreement were the following:

--a preamble, to state the goals and areas of mutual interest of each organization;

--organizational liaison, to establish standardized communication channels, which might include a coordinating council and overlapping representation on committees and governing bodies;

--exchange of data and information. A state agency already in existence might serve as a resource for coordination of information. (Proposed regulations on confidentiality published Dec. 3 will allow the PSRO to share certain data with the HSA. Final regulations might not be published until late next year);

--plan development, described as one of the first orders of business. HSAs should request technical assistance, as well as data, from PSROs in the planning of an AIP and HSP;

--criteria and standards development. HSAs are responsible for health planning that meets the needs of the community or area, while the PSRO standards focus on individual patient care. HSAs should allow PSRO input into the development of their criteria and standards, and provide opportunities for PSRO review and comments.

--plan implementation activities. The agreement should include provisions for PSRO input into HSA review activities, and other areas of mutual concern as well (for example, the organizations might jointly address the issue of long-term-care beds);

--term and modification of the agreement. A timetable should be established for periodic review of the agreement, the contents of which will be subject to modification. HSAs must review and revise, as necessary, their coordination agreements prior to full designation.

6-MONTH DEADLINE

The draft transmittal, presented at the National PSR Council meeting Nov. 22, states that an agreement must be entered into within six months after an HSA has been conditionally designated.

Entering into a written agreement will benefit both PSROs and HSAs, the draft transmittal says. It will enable both organizations to identify their individual objectives without duplication of effort. The coordination of activities should ensure a consistent plan for high-quality health care in their area. According to the guide, PSROs and HSAs should "use the process of developing an agreement to fully explore the potential in their relationship." ■

Favorable response greets draft plan for agreements between PSRO and government

The draft of plans for agreements between the federal government and individual PSROs was circulated last month, with generally favorable response from PSROs. Agreements would replace contracts in regulating the relationship between a PSRO and the federal government.

In his cover letter to PSROs, Michael J. Goran, M.D., director of the Bureau of Quality Assurance, said an agreement would "allow greater program flexibility," and that "a PSRO agreement will be more PSRO-specific and somewhat less restrictive than

the procurement contracts in use at this time."

To achieve greater flexibility, the draft plans call for the responsibility for concluding agreements to fall to an agreement awards officer (AAO), whose sphere would be limited to PSROs, instead of the present contracting officer, who handles contracts for a number of services within the Health Services Administration.

Regulations governing use of agreements are expected to be published in proposed form by April and in final form by September, 1977. ■

National PSR Council is told that health providers hold key to PSRO evaluation

The nation's health-care providers hold the key to any evaluation of the effectiveness of the PSRO program, a DHEW planning officer told the National PSR Council meeting Nov. 22, as that group reviewed an evaluation strategy for fiscal 1977 and 1978. The National Council must produce evaluation reports for Congress in the next two years.

Areas to be addressed by PSRO evaluation studies include inpatient hospital use, inpatient hospital expenditures, ancillary-services utilization and spending, and progress in maintaining medical-care quality.

But, "without the cooperation of providers, there is no hope of providing an evaluation report next year," said Ronald Carlson, deputy director of OPEL. He said DHEW was sending out letters to 300 hospital administrators, seeking their cooperation, and had scheduled meetings with American Hospital Association state people on evaluation. ■

Integrity, clinical skill seen as physician adviser's most essential qualities

An effective physician adviser, whose role is deemed essential to the success of a PSRO program, must possess, above all, integrity, excellent clinical skills and the respect of his colleagues, according to a recent survey of experienced PSRO professionals.

PROFESSIONAL SKILLS RANKED

Seen as least important of eight ranked professional skills were being board-certified or a diplomate, and having knowledge of hospital continuing-medical-education possibilities.

A national survey of PSRO physicians, administrators and review coordinators, conducted by David B. Shelton, director of operations at the Dade-Monroe (Florida) PSRO, also concludes that an effective physician adviser ought to be a keen and analytical observer, and should be cooperative, objective and self-disciplined. Chosen as least important in a list of 18 personal qualities were willingness to delegate responsibility and being empathetic.

Shelton undertook the survey (part of his doctoral dissertation) from fall, 1975, through spring, 1976, while working with the Institute for Professional Standards. Personnel from 23 PSROs responded to his questionnaire. A summary of his results was circulated by the American Association of PSROs.

ADVISER AND ADVOCATE

According to Shelton, a physician adviser, selected from a hospital's medical staff, fills a role once performed by the entire utilization-review committee. He must act as a patient advocate as well as adviser to the professional review coordinator, making decisions on admissions, diagnoses and length-of-stay certifications. His primary responsibility, however, is to decide if patients are inappropriately hospitalized. The power to deny payment for services is unique to the physician adviser.

The PSRO personnel surveyed did not agree on which medical specialty a physician adviser should be chosen from, although 28 percent favored internal medicine and 18 percent specified family medicine or general practice. ■

Christmas heads 'HEW cluster' in Carter transition team

WASHINGTON, D.C.--Heading the "HEW cluster" in President-elect Jimmy Carter's transition office is June J. Christmas, M.D., a black psychiatrist who is on leave as commissioner of the New York City Dept. of Mental Health and Mental Retardation Services.

The transition office has also identified the key people in health who are working on the phase-in to a new administration. They include Robert Havely, 24, the health-issues coordinator for the Carter campaign, and Joseph Onek, 34, an attorney who has been the director of the Center for Law and Social Policy, a public-interest law group. Onek has been active in several lawsuits against the government in environment and health issues. ■

Subscribers will receive an Index to PSRO Update issue numbers 16 through 27 with their January copy of this newsletter. ■

Conference report proposes central role for PSROs in continuing medical education

PSROs should be given a central role in continuing-medical-education programs because, with their data, they can offer valuable assistance in identifying problems of medical quality, says a recommendation proposed in a monograph just published by the Boston University Health Policy Center.

NO BIG FUNDING NEED

"Particular effort must be made," says the recommendation, "to maximize the potential of the PSRO mechanism as an educational vehicle." And this effort need not wait for federal money to pay for PSRO educational activities, the report continues. "Very little in dollar investments" is required to get cooperative programs going between PSROs and medical schools and private medical organizations, the monograph notes.

The monograph resulted from a conference held in Boston last June. The conference was the second in a series of meetings supported by the Robert Wood Johnson Foundation.

RECOMMENDATIONS

Although many conference participants questioned the effectiveness of CME as a quality-assurance measure, they felt that the medical profession should not try to halt CME activities, but rather to modify and improve them. Other recommendations for achieving that goal are:

--Medical schools and physician organizations should be the primary resource for sponsoring and implementing CME programs aimed at physician competence and high-quality health care.

--Alternative approaches to the traditional CME lecture-course format should be developed, including performance-based programs and others dealing with patient-management and communications skills.

--Medical schools must evaluate the degree to which quality-of-care problems are due to deficiencies in medical-student and house-staff training.

--To develop better regional cooperation, the CME-related activities of state government agencies should be integrated with those in the private sector.

The 33-page booklet, titled "Continuing Medical Education and Quality Health Care: What is the Link?", also contains a brief review of the policy issues that led to the recommendations, abstracts of 19 background papers written for the conference (to be published separately) and statements by participants excerpted from the discussions.

Among those participating in the conference were: Clement R. Brown, Jr., M.D., director of medical education at the South Chicago Community Hospital, Chicago, and a former member of the National PSR Council; Michael J. Goran, M.D., director of the Bureau of Quality Assurance, Rockville, Md.; and Alan R. Nelson, M.D., internist, Salt Lake City, and a member of the National PSR Council.

Copies of the monograph are available at $1 each from: Boston University Health Policy Center, 53 Bay State Road, Boston, Mass. 02215.

Subscribers to PSRO Update may receive a free copy of the monograph by writing to: PSRO Update, 720 Harrison Ave., Room 300, Boston, Mass. 02118. ■

National Council predicts PSRO admission reviews will double in FY77

WASHINGTON, D.C.--The National PSR Council is predicting that PSRO reviews of hospital admissions in fiscal 1977 will be double the estimated two million reviews that were conducted during the government bookkeeping year that ended Sept. 30.

The Council's fourth annual report, approved at the board's Nov. 22-23 meeting, predicted four million hospital reviews would be conducted during "a year of significant growth of the PSRO program." At the end of June, 1975, PSROs had reviewed 172,000 hospital admissions. "In essence, the program will move from [being] one that has been primarily developmental to one that is primarily operational," the Council report says. The 1,291 hospitals under PSRO review last June represented an increase from 682 the previous June. ■

Simmons boosts PSRO program, sees public call for U.S. standards

Henry E. Simmons, M.D., former DHEW deputy assistant secretary for quality assurance and now president of the Hunterdon Medical Center, Flemington, N.J., told the annual meeting of the Medical Society of the State of New York that PSRO can be instrumental in helping to rid the health-delivery system of costly, unnecessary practices.

Much of the expensive new medical technology introduced in the United States has been brought on the scene and "widely adopted without proper evaluation," Simmons asserted. In many instances, the development of new instruments or the use of new techniques does not bring any better results, he said. Among costly items are the CAT scanning devices and bypass surgery, "for which evidence justifying massive use is still unavailable," he declared. The Bureau of

Quality Assurance, which operates the PSRO program, is responsible for advising Medicare on the efficacy of new technology.

The public will not tolerate continued variations in the quality of health care throughout the country, Simmons told the New York physicians, and he predicted that as "solid information" begins to emerge from PSRO, there will be increasing public pressure for national standards of care.■

What is the role of PSROs in combatting fraud and abuse in Medicare, Medicaid?

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whether those services were of such an inferior quality as to warrant termination of BHI contracts. Examination of quality is very much the task of the PSRO and it is a serious deficiency in quality of practice that would lead a PSRO to recommend sanctions. In this area of overlap, the PSRO is to take precedence over the PRT, but for this to happen the activities of the two groups will have to be well coordinated.

A POTENTIAL CONFLICT

Added to the difficulty of the potential conflict in the PSRO-PRT relationship is the introduction of the inspector general. If the I.G. enters into investigations of not only cases of fraud but also abuse, it may itself be involved in assessing questions dealing with the quality of care. The I.G.'s role to combat abuse, as the law now stands, gives it open discretion as to what types of cases it wishes to investigate. If, for example, the I.G. feels a PSRO is lax in reporting possible abuses, the I.G. may audit the work of the PSRO (or duplicate its review). The I.G. possesses the statutory power to coordinate DHEW activities in fraud and abuse; one hopes it will do so without preempting the potential contribution of the PSRO and PRT. It seems doubtful that the inspector general could develop an organization large enough to filter out abuses in the local provider level without the close cooperation of BHI and BQA.

In the fraud and abuse area, as the bureaucracy is now developing, there is need to insure that the activities of the various groups are coordinated as effectively as possible to prevent unnecessary duplication and competition.

A DANGEROUS CHANGE?

Expanding the role of the PSRO into the fraud area may be viewed as a dangerous alteration. The PSRO needs the support of the physician community, which support may be even harder to muster if the organization is seen as an investigative tool of DHEW. In addition, some may argue that assigning PSRO reviewers the task of investigating fraud may be too large a grant of power, adding up to a program of ineffective self-regulation.

It does not seem, however, that by expanding the PSRO function to deal with fraud, the character of the organization would be changed, for its primary function would still be medical peer review. The PSRO, even if it had a role in fraud detection, would never be in the position of sanctioning providers or terminating their contracts to deliver care. If the PSRO investigation uncovers fraud, the inspector general's office should be notified and the two groups together should handle the problem with the onus on the I.G. In turn, the PSRO should act as the primary agency for making determinations about the quality of care, and in that capacity, it should be relied upon by both PRTs and the I.G.

AN AWKWARD BUREAUCRACY

To ignore the investigative potential of local PSROs in dealing with fraud and in rendering judgments about the quality of medical care can lead to creation of an awkward bureaucracy that may not be able to detect Medicare and Medicaid fraud and abuse and effectively assess the nature of that abuse, especially if it involves questions about the quality of care.■

Quadruple Blind

An occasional editorial diversion by PSRO Update in which no one involved knows what is going on...

WASHINGTON, D.C.--Officials of DHEW's Bureau of Quality Assurance, while steadfastly denying any change in the PSRO program's policy against any form of "cookbook medicine," this week refused on several occasions to either confirm or deny one of the most persistent rumors in this rumor-rife city--that President-elect Jimmy Carter will soon name gourmet cook, author and television personality Julia Child as the new BQA director.

Super-chef Child, whose culinary exploits took the drudgery of cooking and made it a chic pasttime for females and males alike, is expected to hold a press conference this week to deny the alleged appointment, and to sign first edition copies of her new book, The Joy of Cookbook Medicine.

From its earliest days, the PSRO program has been criticized as one that will lead to cookbook medicine through the implementation of federally required norms, standards and criteria for medical treatment.■

ANALYSIS

What is the role of PSROs in combatting fraud and abuse in Medicare, Medicaid?

By John Blum, J.D.

With the growing concern about fraud and abuse in federal health programs, the government has begun to attack these problems through the new office of inspector general and the program-review teams of the Bureau of Health Insurance. But what should be the role of PSROs in combatting fraud and abuse?

RECOMMENDS SANCTIONS

Currently, the PSRO possesses the legislative authority to recommend sanctions against practitioners who deliver care that is inappropriate, unnecessary or not adequately documented. The PSRO authority lies in identifying abuses and applying corrective educational measures to alleviate those abuses. It is only in the case of a pattern of violation of PSRO guidelines or in the case of a flagrant violation that the PSRO will recommend to the State PSR Council (and ultimately to the Secretary of DHEW) that sanctions be leveled. The PSRO, while it has the authority to launch investigations dealing with suspected abuse, does not have the power to impose statutory sanctions; this power rests only with the DHEW Secretary.

It has been proposed (in the Talmadge Medicare bill) that the role of the PSRO be expanded to deal with both abuse and fraud. To alter the role of the PSRO, a change would be required in the present law, for while fraud issues may occasionally fall within the PSRO's legislatively mandated sphere, fraud investigation does not.

(Fraud has been defined generally to mean a deceitful practice or willful device resorted to with intent to deprive another of his right or in some manner to do him injury. As distinguished from negligence, it is always positive and intentional. Abuse is generally defined as making excessive or improper use of something.)

FRAUD IN REPORTS, BILLING

While the abuses the PSRO uncovers may be fraudulent, violation of PSRO norms, standards and criteria that may lead to sanction does not necessarily have to involve fraud. A physician who renders treatment not in keeping with PSRO guidelines will generally do so without a deceitful purpose. The fraud that occurs in treatment of Medicare and Medicaid patients most generally occurs in the area of false reports and fraudulent billing, which are things the PSRO review may not pick up. However, fraud that involves excessive or inferior quality treatment would be picked up by a PSRO review.

The program-review team that was mandated in the 1972 Medicare amendments is just now starting to be implemented in various DHEW regions. The PRT, run by the Bureau of Health Insurance, is designed to act as an investigative body to check fraudulent and excessive billing for Title 18 (Medicare) and to investigate medical treatment which is excessive or of inferior quality. Much of the PRT's work will focus on ambulatory care.

Unlike the PSRO, the PRT cannot conduct investigations on its own volition, but must do so under the direction of BHI regional offices. Recommendations for terminating BHI provider contracts must first be made by the regional BHI director, but such recommendation must receive the concurrence of of the PRT in areas of their jurisdiction. The ultimate decision to terminate a BHI contract or to exclude a provider is made by the director of BHI in conjunction with the program integrity branch, which coordinates the PRTs nationally.

THE I.G.'s AUTHORITY

Under the Medicare amendment passed in October, 1976, the office of the inspector general was established to combat fraud within DHEW, and a special section of that office is to be devoted to dealing with fraud and abuse in Medicare and Medicaid programs. The inspector general's office is to act as an independent unit directly under the Secretary of DHEW with power to audit and investigate (and recommend prosecution of) Medicare and Medicaid providers. Power is granted to the I.G. to coordinate the efforts of the various groups within DHEW dealing with the fraud and abuse question. There is a problem in the law creating the I.G. office in that it fails to define either fraud or abuse; thus the scope of authority the inspector's office will have is not clear.

Theoretically, the PRT, I.G. and PSRO all have distinguishable roles in the fraud and abuse area, but in practice it is not as easy to separate their functions, especially in the area of abuse arising out of poor medical treatment. The role of the PRT in some instances involves examining the quality of services rendered to determine

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